Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: January 4, 2024
Inspection Number: 2023-1013-0004
Inspection Type: Proactive Compliance Inspection
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Case Manor Community, Bobcaygeon

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 14, 15, 18, 19, 20, 2023

The following intake(s) were inspected:

- Intake: #00103549 - PCI inspection

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement

Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan related to responsive behaviours.

Rationale and Summary

During observations of a resident room, Inspector #741831 noted a specified alarming device. The residents plan of care identified the resident was at risk for specified responsive behaviour and one of the interventions included the specified alarming device was not to be used.

A PSW confirmed the alarming device was not to be used. During an interview, with the Director of Care (DOC), they indicated that the resident had history of a specified responsive behaviour related to the use of the specified alarming device and later confirmed the alarming device had been removed.

Failing to ensure that the care set out in plan of care was provided to a resident related to responsive behaviours, placed the resident at risk for physical injury.

Sources: Observations of a resident and review of their health records, and interview with staff. [741831]

WRITTEN NOTIFICATION: Duty to respond

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
Duty to respond
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

1.The licensee failed to respond to the Residents' Council within ten days in writing after concerns related to food and nursing care were brought forward.

Under s. 63 (1) 6 of the FLTCA, 2021, a Residents' Council of a long-term care home has the power to advise the licensee of any concerns or recommendations the Council has about the operation of the home.

Rationale and Summary

A review of the Resident Council meeting minutes and the Resident Food Committee minutes for specified months in 2023, indicated concerns were brought forward regarding food and resident care. Inspector #741831 was not provided with any written responses to the Resident Council meeting minutes concerns or recommendations.

The Resident Council President indicated that the staff would provide a verbal response to

concerns brought forward and/or discuss the changes at the following meetings. They confirmed they never received a written response.

The Director of Support Services indicated that they had attended the Resident Council meetings to discuss the food concerns. They confirmed that they did not respond in writing to the concerns brought forward by the Resident Council. The Director of Resident Programs & Admissions indicated that most of the resident concerns were resolved at the time of the Resident Council meeting where possible.

By failing to respond in writing to concerns and recommendations brought forward by Resident Council, results in a risk of concerns and recommendations not being addressed or resolved.

Sources: Record review of Resident Council meeting minutes and interview with the Director of Support Services, Director of Resident Programs & Admission, Resident Council president. [741831]

2.The licensee failed to respond in writing to the Family Council's concern or recommendations within ten days they were brought forward.

Under s. 63 (1) 8 of the FLTCA, 2021, a Family' Council of a long-term care home has the power to advise the licensee of any concerns or recommendations the Council has about the operation of the home.

Rationale and Summary

A review of the Family Council meeting minutes for a specified period, which included recommendations for the operation of the home.

The Family Council President indicated they have not received a written response to the concerns or recommendations discussed.

The licensee was not able to provide Inspector #741831 with the written response to the meeting minutes..

By failing to respond in writing to the concerns and recommendations brought forward by Family Council, there was a risk that concerns about the operation of the home, might not be addressed or resolved.

Sources: Record review of Family Council meeting minutes and interview with the Family Council President. [741831]

WRITTEN NOTIFICATION: Windows

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents had a screen and could not be opened more than 15 centimetres (cm).

Rationale and Summary

During that initial tour of the home, observations of windows by Inspector #741831 identified several windows in common areas that did not have screens present. A resident room window also was opened greater than 15 cm.

The Executive Director (ED) confirmed the window in the resident room was to have a bracket that limited the window opening but was broken.

During an interview with the Maintenance indicated that each vacant room required a window audit prior to a new resident moving in and they confirmed verification of screens was not part of that audit. The Maintenance confirmed a new bracket had been installed to limit the opening of the window greater than 15 cm that day.

By failing to ensure that every window in the home that opens to the outdoors and is accessible by residents had a screen and was not able to be opened greater than 15 cm, places residents at risk for injury due to the risk of the waterway next to the home and the risk of unwanted pest entering the residents' home.

Sources: Observations, and interviews with the Executive Director (ED) and Maintenance. [741831]

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary

During observations of two resident rooms, Inspector #741831 noted the call bells were not accessible or had been disengaged. Two separate PSWs confirmed the call bells were not accessible or had been disengaged.

The Director of Care indicated the expectation was that call bell cords were to be easily seen and accessible. As a result of the inspection, the resident -staff communication in each of the identified resident rooms had been rectified.

By failing to ensure that the resident - staff communication and response system was easily seen, accessed, and used by residents, staff, and visitors at all times, placed residents at risk of harm when they are unable to call of assistance.

Sources: Observations in two resident rooms and interview with staff. [741831]

WRITTEN NOTIFICATION: Menu planning

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

Rationale and Summary

Observation of the lunch dining service by Inspector #111 noted two residents had not been offered the soup at the beginning of the meal. Three residents that were identified as a nutritional risk were identified with a specified texture. Those residents had selected one of the meal choices and all of the meal items had not been provided.

Interview with a Dietary Aid (DA) confirmed none of the residents on the specified textures were provided all of the meal items for the specified meal choice. The DA was aware of the process to follow when items from a meal choice were not made available by the main kitchen and confirmed they did not take any actions.

During separate interviews with the Director of Support Services (DSS) and the Registered Dietician (RD), they each confirmed the residents with specified textures were at a nutritional risk. They both confirmed awareness that a number of the residents in the home on a specified texture who requested the specified meal choice did not receive all of the meal items.

Failing to ensure that resident's at nutritional risk, including a number of residents, were offered and made available the planned menu items resulted in the residents not receiving their planned nutritional intake.

Sources: observation of dining service, and staff interviews. [111]

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure the written policies and protocols for medication management that were developed, were implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary

During the observation of a medication administration completed on a specified unit, for a resident, Inspector #111 noted the resident had been prescribed a pain topical ointment but no indication where the ointment was to be applied.

During an interview with an RPN, they indicated all prescribed topical ointments were applied by the PSWs and stored in a specified area. The RPN indicated the resident's pain ointment was to be applied to a specified area. Interview with a PSW indicated they had provided care to the resident and had no awareness the resident was prescribed a pain ointment and was not included in their electronic record to be applied. The PSW identified a different location for where the resident had complaints of pain.

Observation of the topical ointments for the specified resident identified two different ointments were available for the resident. The prescribed pain ointment was not available.

Review of the PSW/RCA application of topical ointments policy indicated the nurse was to place the order onto the PSW electronic Point of care (POC) documentation and ensure it was maintained. They were to update the residents care plan and

supervise and monitor the PSWs activities either directly with observation or indirectly through report and follow up on the resident's situation and condition. The policy did not include where the prescribed treatments were to be stored and what actions to take when the treatments were expired or discontinued.

Review of the resident's health record revealed in the care plan under pain, the resident had pain in a different location that had been identified by the PSW and RPN. The resident had non-verbal indicators of pain with demonstrated responsive behaviours and the pain treatments were to be administered by the registered staff. There was no indication of any prescribed ointments in the residents POC. The physicians' orders indicated the two identified ointments in the storage area had been discontinued a number of months earlier. Review of the resident's progress notes indicated the resident had ongoing responsive behaviours that indicated possible pain and no indication the resident was offered the prescribed pain ointment.

During separate interviews with the acting DOC and the Executive Director (ED), they confirmed there had not been any evaluation or updates to the identified policy for a number of years and were unaware that the policy was not being implemented as indicated.

Failing to ensure that the written policy for the administration of treatment creams by PSWs was implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices for a resident, resulted in the resident not receiving the prescribed pain ointment as needed and previous topical ointments not being discontinued as required.

Sources: observations, a residents health record, PSW/RCA application of topical ointments policy and interview of staff. [111]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 1.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons: 1. The home's Administrator.

The licensee failed to ensure that the Executive Director was a member of their continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes for the CQI committee for a specified month, indicated that only the Physiotherapist, Director of Care, Registered Dietitian and Associate Director of Care was in attendance.

The licensees Leadership & Quality Committee policy indicates that the Care community Leadership Team with Executive Director (ED) assigned as Chair, Other individuals to be invited as required. The frequency of meetings are monthly or more often as called by the Chairperson.

The Associate Director of Care (ADOC) confirmed the following individuals were not present at the Quality monthly meeting. The Executive Director (ED) indicated as newly appointed to the role, that the CQI committee was a focus for the new year.

By failing to include at least the following persons mentioned on the CQI team, the

lost opportunity for input from a diverse team negatively effects all residents.

Sources: Record review of the Quality and Resident Safety meeting minutes, Leadership & Quality Committee policy and interviews with the ADOC and Executive Director. [741831]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 3.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons: 3. The home's Medical Director.

The licensee failed to ensure that the home's Medical Director was a member of their continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes for the CQI committee for a specified month in 2023, indicated that only the Physiotherapist, Director of Care, Registered Dietitian and Associate Director of Care was in attendance.

The licensees Leadership & Quality Committee policy indicates that the Care community Leadership Team with Executive Director (ED) assigned as Chair, Other individuals to be invited as required. The frequency of meetings are monthly or more often as called by the Chairperson.

The Associate Director of Care (ADOC) confirmed the following individuals were not present at the Quality monthly meeting. The Executive Director (ED) indicated as newly appointed to the role, that the CQI committee was a focus for the new year.

By failing to include at least the following persons mentioned on the CQI team, the lost opportunity for input from a diverse team negatively effects all residents.

Sources: Record review of the Quality and Resident Safety meeting minutes, Leadership & Quality Committee policy and interviews with the ADOC and Executive Director. [741831]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons: 6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee failed to ensure that the home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider was a member of their continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes for the CQI committee for a specified month in

2023, indicated that only the Physiotherapist, Director of Care, Registered Dietitian and Associate Director of Care was in attendance.

The licensees Leadership & Quality Committee policy indicates that the Care community Leadership Team with Executive Director (ED) assigned as Chair, Other individuals to be invited as required. The frequency of meetings are monthly or more often as called by the Chairperson.

The Associate Director of Care (ADOC) confirmed the following individuals were not present at the Quality monthly meeting. The Executive Director (ED) indicated as newly appointed to the role, that the CQI committee was a focus for the new year.

By failing to include at least the following persons mentioned on the CQI team, the lost opportunity for input from a diverse team negatively effects all residents.

Sources: Record review of the Quality and Resident Safety meeting minutes, Leadership & Quality Committee policy, and interviews with the ADOC and Executive Director. [741831]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons: 7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee failed to ensure that at least one employer of the licensee who is a member of the regular nursing staff of the home was a member of their continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes for the CQI committee for a specified month in 2023, indicated that only the Physiotherapist, Director of Care, Registered Dietitian and Associate Director of Care was in attendance.

The licensees Leadership & Quality Committee policy indicates that the Care community Leadership Team with Executive Director (ED) assigned as Chair, Other individuals to be invited as required. The frequency of meetings are monthly or more often as called by the Chairperson.

The Associate Director of Care (ADOC) confirmed the following individuals were not present at the Quality monthly meeting. The Executive Director (ED) indicated as newly appointed to the role, that the CQI committee was a focus for the new year.

By failing to include at least the following persons mentioned on the CQI team, the lost opportunity for input from a diverse team negatively effects all residents.

Sources: Record review of the Quality and Resident Safety meeting minutes, Leadership & Quality Committee policy and interviews with the ADOC and Executive Director. [741831]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons: 8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee failed to ensure that the was a Personal Support Worker (PSW) member of their continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes for the CQI committee for a specified month in 2023, indicated that only the Physiotherapist, Director of Care, Registered Dietitian and Associate Director of Care was in attendance.

The licensees Leadership & Quality Committee policy indicates that the Care community Leadership Team with Executive Director (ED) assigned as Chair, Other individuals to be invited as required. The frequency of meetings are monthly or more often as called by the Chairperson.

The Associate Director of Care (ADOC) confirmed the following individuals were not present at the Quality monthly meeting. The Executive Director (ED) indicated as newly appointed to the role, that the CQI committee was a focus for the new year.

By failing to include at least the following persons mentioned on the CQI team, the lost opportunity for input from a diverse team negatively effects all residents.

Sources: Record review of the Quality and Resident Safety meeting minutes, Leadership & Quality Committee policy and interviews with the Associate Director of Care and Executive Director. [741831]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons: 9. One member of the home's Residents' Council.

The licensee failed to ensure that the one member of the home's Resident Council was a member of their continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes for the CQI committee for a specified month in 2023, indicated that only the Physiotherapist, Director of Care, Registered Dietitian and Associate Director of Care was in attendance.

The licensees Leadership & Quality Committee policy indicates that the Care community Leadership Team with Executive Director (ED) assigned as Chair, Other individuals to be invited as required. The frequency of meetings are monthly or more often as called by the Chairperson.

The Associate Director of Care (ADOC) confirmed the following individuals were not

present at the Quality monthly meeting. The Executive Director (ED) indicated as newly appointed to the role, that the CQI committee was a focus for the new year.

By failing to include at least the following persons mentioned on the CQI team, the lost opportunity for input from a diverse team negatively effects all residents.

Sources: Record review of the Quality and Resident Safety meeting minutes, Leadership & Quality Committee policy and interviews with the ADOC and Executive Director. [741831]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons: 10. One member of the home's Family Council, if any.

The licensee failed to ensure that the one member of the home's Family Council was a member of their continuous quality improvement (CQI) committee.

Rationale and Summary

A review of the meeting minutes for the CQI committee for a specified month in 2023, indicated that only the Physiotherapist, Director of Care, Registered Dietitian and Associate Director of Care was in attendance.

The licensees Leadership & Quality Committee policy indicates that the Care

community Leadership Team with Executive Director (ED) assigned as Chair, Other individuals to be invited as required. The frequency of meetings are monthly or more often as called by the Chairperson.

The Associate Director of Care (ADOC) confirmed the following individuals were not present at the Quality monthly meeting. The Executive Director (ED) indicated as newly appointed to the role, that the CQI committee was a focus for the new year.

By failing to include at least the following persons mentioned on the CQI team, the lost opportunity for input from a diverse team negatively effects all residents.

Sources: Record review of the Quality and Resident Safety meeting minutes, Leadership & Quality Committee policy and interviews with the ADOC and Executive Director. [741831]
[741831]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall comply with O.Reg. 246/22, s. 102(2)(b).

Specifically, the licensee shall:

1. Re-train RN #116, PTA, DA #109, PSW #100, #101, #122 on the proper use of masks. The re-training records are to be provided to the inspector immediately upon request.
2. Re-train PSW #100 and #101 on hand hygiene protocols. The re-training records are to be provided to the inspector immediately upon request.
3. The IPAC Lead or their back-up designate trained in IPAC, is to complete daily audits for two weeks on each unit at various times to observe if staff are wearing their masks correctly and offering residents assistance with hand hygiene during nourishment. They are to provide on the spot education for those staff that are found to non-compliant. The audits are to include which staff were provided re-education. The audits are to be provided to the Inspector immediately upon request.

Grounds

1.The licensee failed to implement the IPAC standard issued by the Director with respect to infection prevention and control.

According to IPAC standard, 9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: f) Additional PPE requirements including appropriate selection application, removal and disposal.

Rationale and Summary

Upon Inspector #111 entering the nursing station on a specified unit, an RPN and RN were noted sitting approximately less than two feet apart at the nursing desk. The

RN had not donned their mask correctly. Upon seeing the Inspector, the RN then applied their mask correctly.

During an interview with acting DOC, they confirmed the expectation was that all staff were required to wear the medical mask correctly when at the nursing station and other staff were present.

Failing to ensure the registered staff member donned their mask correctly leads to transmission of infections.

Sources: observations and interview with the DOC. [111]

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary

During observations throughout the home, on various dates, Inspector #741831 noted several occasions where the staff were not wearing a mask or not donning their mask correctly.

The Physiotherapist Assistant (PTA) was observed with their mask below their nose or mask completely removed. It was observed a resident was doing bike exercises in close proximity to the PTA,, and the staff members mask was completely removed. When asked if they require to wear a mask, they indicated they did and applied the mask. Inspector did not observe the PTA complete hand hygiene after reapplying their used mask.

A Dietary Aid (DA) was observed on two occasions not wearing their mask appropriately. The first occasion, the staff member pulled their mask over their nose

when they saw the inspector. The inspector returned to the resident dinning room moments after, and their mask was pulled below their nose again. Inspector asked the Dietary Aid if the staff are required to wear their mask in resident spaces. The Dietary Aid apologized and indicated they are required to always wear their mask.

Two PSWs where observed with their mask pulled below their chin while assisting a resident in their room, they indicated they were very hot and felt an irritate in the air.

Another PSW was observed walking into a resident's room with a mask below their nose.

The IPAC lead confirmed all staff are trained on the appropriate use of a mask. The IPAC Lead indicated that the staff were required to wear a mask correctly.

Sources: Observations made throughout the inspection, Interview of staff and the IPAC Lead. [741831]

2.The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022" (IPAC Standard) additional requirements section 10.4 The licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, which includes support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary

During observations throughout the home, staff were observed not assisting residents with hand hygiene during nourishment. The nourishment cart had alcohol-based hand rub (ABHR) available.

Two PSWs were observed not offering ABHR to the residents while offering afternoon nourishment. When asked, PSW #101 confirmed awareness that the staff were to offer the ABHR to the residents prior to nourishment.

The IPAC Lead confirmed the expectation of staff was to offer support to the residents with hand hygiene prior to nourishment.

By failing to ensure the residents were supported with hand hygiene prior to nourishment put the residents at risk of infectious diseases.

Sources: Observations of mid-morning nourishment being provided to residents, interview with staff and the IPAC Lead. [741831]

This order must be complied with by: March 8, 2024.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.